Health & Place 39 (2016) 204–211

Contents lists available at ScienceDirect

Health & Place

journal homepage: www.elsevier.com/locate/healthplace

The double burden of neoliberalism? Noncommunicable disease policies and the global political economy of risk ☆

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ARTICLE INFO

Article history:
Received 1 September 2014
Received in revised form
26 May 2015
Accepted 15 June 2015
Available online 28 April 2016

ABSTRACT

The growing prevalence of NCDs in low- and middle-income countries (LMICs) is now recognized as one of the major global health policy issues of the early 21st century. Current official approaches reflect ambivalence about how health policy should approach the social determinants of health identified by the WHO Commission on the topic that released its report in 2008, and in particular the role of macro-scale economic and social processes. Authoritative framing of options for NCD prevention in advance of the September, 2011 UN high-level meeting on NCDs arguably relied on a selective reading of the scientific (including social scientific) evidence, and foregrounded a limited number of risk factors defined in terms of individual behavior: tobacco use, unhealthy diet, alcohol (ab)use and physical inactivity. The effect was to reproduce at a transnational level the individualization of responsibility for health that characterizes most health promotion initiatives in high-income countries, ignoring both the limited control that many people have over their exposure to these risk factors and the contribution of macro-scale processes like trade liberalization and the marketing activities of transnational corporations to the global burden of NCDs. An alternative perspective focuses on "the inequitable distribution of power, money, and resources" described by the WHO Commission, and the ways in which policies that address those inequities can avoid unintentional incorporation of neoliberal constructions of risk and responsibility.

1. Introduction and background

The United Nations high-level meeting on non-communicable diseases (NCDs; subsequently the NCD Summit) in September, 2011 took place a decade after the first such meeting in the history of the UN, which addressed the AIDS epidemic and took place in 2000. The NCD Summit was a milestone in a long period of activity by public health researchers and policy-makers. It provided new visibility to a category of diseases that, taken together, account for more than three out of every five deaths worldwide; roughly four out of five of those deaths from NCDs occur in low- or middle-income countries (World Health Organization, 2010). Thus, among its other accomplishments the Summit foregrounded the rapidly rising incidence of NCDs in low- and middle-income countries as an unwelcome form of convergence that blurs the spatial lines between "core" and "periphery," like many of the economic processes associated with globalization (*cf.* Robinson, 2002). Indeed, globalization of certain patterns of development leading to rapid dietary transitions can be seen as a key driver of that convergence (Popkin et al., 2012; Popkin, 2014), although the issue received limited attention at the Summit. NCDs do not take the place of communicable diseases like HIV/AIDS, tuberculosis, and malaria; rather, the two categories combine to produce what is often referred to in the literature as a double or even multiple[2] burden of disease.

The main output of the NCD Summit itself was a negotiated Political Declaration, passed by the General Assembly three days *before* the start of the Summit (United Nations General Assembly, 2011). Like many such documents generated on the basis of a *de facto* unanimity rule, the Declaration was long on generalities and ringing statements of principle but notably short on specific targets and commitments. Responding to a near-final draft of the Declaration in

DOI of original article: http://dx.doi.org/10.1016/j.healthplace.2015.06.005
☆A publisher's error resulted in this article appearing in the wrong issue. The article is reprinted here for the reader's convenience and for the continuity of the special issue. For citation purposes, please use the original publication details. Health & Place, Volume 34, July 2015, Pages 279–286.
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http://dx.doi.org/10.1016/j.healthplace.2016.04.003
1353-8292/

[2] Multiple, because in many countries injury rates, in particular from road traffic accidents, are rising in parallel with the incidence of NCDs, exhibiting a pronounced socioeconomic gradient.

advance of the Summit the NCD Alliance, a global network founded in 2009 by four international professional organizations concerned with NCDs,[3] stated that the Declaration "[fell] short in several key areas," including the absence of time-bound targets for NCD reduction, weak language on restricting the availability and use of alcohol, and lack of concrete commitments to increase funding for dealing with NCDs (Noncommunicable Disease Alliance, 2011).

These perceived shortcomings were partly addressed by a subsequent initiative led by the World Health Organization (WHO) that generated, in November 2012, a proposed set of indicators of progress and a set of targets for prevention and control of NCDs (World Health Organization, 2013a). The most fundamental of these was the objective of a 25 percent reduction in premature mortality from NCDs by 2025. These indicators and targets were endorsed by a resolution of the 2013 World Health Assembly, the decision-making body of WHO member states. They are voluntary and non-binding; indeed, it is difficult to envision a mechanism that would give such indicators and targets the force of treaty commitments or their equivalents in international law. Nevertheless, the head of one of the constituent organizations of the NCD Alliance described the targets in glowing terms, as signaling "major progress in the fight against diabetes and noncommunicable diseases" (Keeling, 2013). They have now been incorporated into WHO's most recent Action Plan for preventing and controlling NCDs (World Health Organization, 2013b), and into the outcome resolution of a 2014 follow-up meeting of the General Assembly (United Nations General Assembly, 2014).

We focus here, first of all, on the antecedents and subsequent manifestations of the Summit's emphasis on four major groups of NCDs-cancer, cardiovascular diseases, chronic obstructive pulmonary disease (COPD) and diabetes-and on four major risk factors identified as the major contributors to rising NCD incidence: tobacco use, unhealthy diet, physical inactivity and the harmful use of alcohol. This algorithm reflected the content of an earlier WHO Action Plan (World Health Organization, 2008) on NCDs, which was invoked both in the General Assembly resolution establishing the Summit and in the Political Declaration; it was also used to organize WHO's 2010 status report on NCDs (World Health Organization, 2010) and the "about NCDs" section of the web site WHO offered as part of preparations for the Summit.[4] The 2008 Action Plan, in turn, referenced an NCD strategy document and resolution on NCDs adopted by the World Health Assembly in 2000 (World Health Organization, 2000). With the addition of alcohol abuse to the list of behaviors and one omission, which we address later, a remarkable consistency exists among the 2000 document's statement that the NCDs in question "are linked by common preventable risk factors related to lifestyle," i.e. tobacco use, unhealthy diet and physical inactivity; WHO's 2010 Status Report assertion that "NCDs *are caused, to a large extent*, by four behavioral risk factors that are pervasive aspects of economic transition, rapid urbanization and 21st-century lifestyles: tobacco use, unhealthy diet, insufficient physical activity and the harmful use of alcohol" (World Health Organization, 2010, p. vii, emphasis added); and the statement in a United Nations report issued as background to the conference that NCDs "*are largely caused by* four shared behavioral risk factors" (United Nations Secretary-General, 2011, p. 1, emphasis added). As one might expect, the focus on these risk factors carries over to the November 2012 indicators and targets, which are intended to guide national NCD policies and strategies. Our focus is on this consistency and its policy implications, rather than on the Political Declaration considered in isolation.

Given the relative lack of attention to NCDs in global health policy and in the health policies of many low- and middle-income countries (LMICs), it is difficult to critique any effort to foreground prevention and treatment, lest the critique be seen as questioning their importance. That is not our intention here. We begin from the proposition that identification of behavioral risk factors as "causes" is neither scientifically complete nor self-evident. Rather, the focus and language of the Declaration, antecedent documents and subsequent policy initiatives reproduce a "biomedical individualism" (Baum et al., 2009, p. 1968–1969) that provides an incomplete picture of the influences on health and illness, and one that is fundamentally at odds with the focus on structural or "upstream" factors (Marmot, 2000) articulated by the WHO Commission on Social Determinants of Health. That Commission's report focused on how "a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics" leads to inequitable distribution of opportunities to lead a healthy life, within and across national borders (Commission on Social Determinants of Health, 2008, p. 1). Biomedical individualism dominates the perspective of at least one post-Summit assessment of how the targets in question are to be achieved (Bonita et al., 2013). As in the high-income world, a focus on risk factors in LMICs may divert attention from the political economy of NCDs-specifically, the contribution of transnational corporations and trade and investment agreements to rising incidence rates. Some aspects of that neglect were commented upon in the lead-up to the NCD Summit; others remain unexplored and require further investigation, as does the broader process of issue definition and agenda-setting both pre-and post-Summit.

That process, in our view, often reflects the more general, and unreflective, incorporation into health promotion strategies of assumptions grounded in neoliberal rationality. Among other things, such a rationality presumes and promotes the cultivation of self-governing subjects who take an entrepreneurial approach to the management of their health. Such an approach frames the body as a site of investment, with the investment taking the form of such practices as improving one's diet, avoiding tobacco and excessive alcohol consumption, and engaging in regular, physical activity (Glasgow, 2005, 2012). That rationality is the first of our foci in this paper. The second is a related set of research questions having to do with how the international agenda for NCD policy has been set, and how authoritative knowledge about NCD etiology and causation is socially produced.

2. Risk, responsibility, and neoliberalization

WHO's 2008 Action Plan on NCDs acknowledged that "health gains can be achieved *much more readily* by influencing public policies in sectors like trade, taxation, education, agriculture, urban development, food and pharmaceutical production than by making changes in health policy alone" and that: "throughout the life course, inequities in access to protection, exposure to risk, and access to care *are the cause of* major inequalities in the occurrence and outcome of non-communicable diseases" (World Health Organization, 2008, p. 13, emphasis added). This is quite a different view of causation from that cited in the preceding paragraphs, one that is closer to the WHO Commission's approach. Yet when the plan moved on to highlighting the major risk factors for NCDs, and promoting interventions to reduce the prevalence of that risk, a notable shift occurred away from social determinants of health and toward atomistic behaviouralism. This is an instance of lifestyle drift: "the tendency for policy to start off recognizing the need for action on upstream social determinants of health inequalities only to drift downstream to focus largely on individual lifestyle factors" (Popay et al., 2010, p. 148). The logic of such transitions is far from self-evident; they require explanation. Notable in this context is the Political Declaration's

[3] The International Diabetes Federation, World Heart Federation, Union for International Cancer Control, and the International Union against Tuberculosis and Lung Disease.

[4] See http://www.who.int/nmh/events/un_ncd_summit2011/en/index.html (last accessed August 12, 2014).